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POSTRETIREMENT HEALTH CARE BENEFITS FOR PUBLIC EDUCATION EMPLOYEES

Results from a Survey of State and Large Local Associations

National Education Association
Research Division

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Executive Summary

The issue of retiree health care benefits revolves around availability, adequacy, and affordability of these benefits. Using empirical data gathered from the state and large local education Associations, this study fills an important gap in our knowledge about how state and local governments are dealing with the issue.

The results show that retiree health care benefits are not universally available. Eight out of ten school districts and six out of ten states offer a health plan for retired education employees.

Adequacy of benefits is particularly important for retirees. Retirees have special health care coverage needs—for example, coverage for long-term care. The results show that only one out of four state plans offers long-term care benefits. The results also show that retiree health plans frequently offer health maintenance organization (HMO) and preferred provider organization (PPO) options. A retiree health plan including HMOs and PPOs is less appealing and inadequate for retirees because it limits the choice of providers, limits retirees' ability to move to other states, and encourages adverse selection.

The major issue in the provision of retiree health care benefits is not their availability but their affordability and how they are paid for. The results show that retirees are better off under statewide health plans than under school district plans. A greater percentage of state plans, compared with district plans, pay the full cost of a retiree's health insurance premium. This percentage is even greater for those states where the plan is administered by a retirement system.

The findings of this study have important implications for the Associations. The Associations need to educate and to organize members about health care issues. The Associations need to look at how the health care system in their own state is organized and financed and explore the possibility of establishing a statewide retiree health plan that offers adequate and affordable health care benefits to retired education employees.

Introduction

The issue of retiree health care benefits revolves around availability, adequacy, and affordability of these benefits. Using empirical data gathered from the state and local education Associations, this study fills an important gap in our knowledge about how state and local governments are dealing with the issue. The study examines the following specific questions: Are health care benefits available to retired public education employees? How are state and local governments providing these benefits? Are the benefits provided through a retirement system? Are they adequate and affordable?

The provision of health care benefits in the United States seems to be in a turmoil. The United States is the only country in the world that spends more than 11 percent of its gross national product (GNP) on health care and yet 35 million of its citizens still are without health insurance. The United States also may be the only country in the world in which health care costs are rising twice as fast as the Consumer Price Index (CPI) and where almost all efforts to contain health care costs have failed. The National Education Association's concern over the turmoil arises from the squeeze that health care costs are placing on the resources available for increases in direct compensation of education employees.

In the middle of this turmoil is the issue of retiree health care benefits. The discussion about this issue mainly revolves around three topics: availability, affordability, and adequacy of retiree health care benefits.

The availability of retiree health care benefits seems to be at stake because of the rising cost of health care and the existence of a large unfunded liability for retiree health care benefits. Health care costs are rising faster than our ability or willingness to pay for them. There is a large unfunded liability for retiree health care benefits because, unlike pensions, these benefits are generally funded on a pay-as-you-go basis.

The adequacy of retiree health care benefits is being questioned both by consumers and policy-makers. These benefits rarely include coverage for long-term care and preventive health care services. They often include health maintenance organizations (HMOs) and preferred provider organizations (PPOs). HMOs and PPOs impose unnecessary restrictions on the retiree's mobility and choice of providers; therefore, they are inadequate.

The affordability of retiree health care benefits is being threatened by the fact that the rise in health care cost is outpacing inflation and cost-of-living adjustments (COLAs). The proposed Financial Accounting Standards Board (FASB) ruling is raising new concerns about an employer's ability to afford to provide retiree health care benefits in the future. FASB, private sector regulator of accounting procedures, is asking companies to accrue liability for retiree health care benefits in their balance sheets. If the Government Accounting Standards Board (GASB), FASB's counterpart in the public sector, follows suit, the new rules will magnify state and local budget deficits and make retiree health care benefits even more unaffordable for state and local governments.

Significance of Retiree Health Care Issue

The issue of retiree health care benefits has become a matter of great national significance. To deal with the issue, the U.S. Congress is proposing changes in the nation's Medicare program, the program that provides health care benefits to 30 million elderly and disabled Americans. Some of these changes were being proposed under the Medicare Catastrophic Health Insurance legislation, which has now been repealed. Other changes are likely to take place through several long-term care proposals that are being considered by the Congress. To control retiree health care costs, the U.S. Congress is also expected to introduce physician payment reforms accompanied by a stringent quality assurance program.

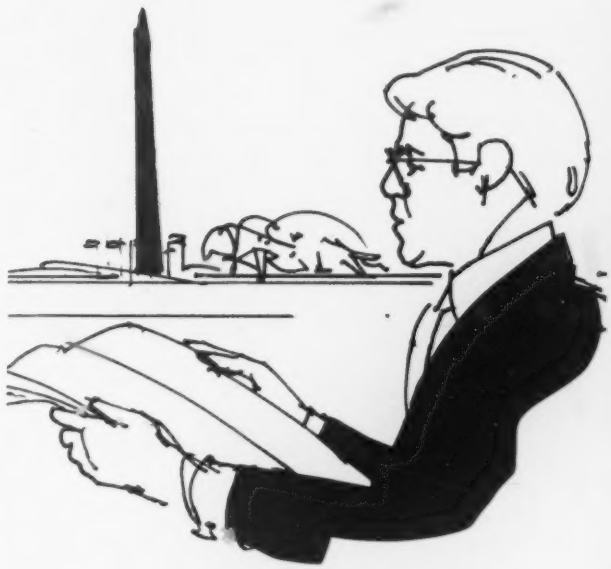
For education employees, the issue of retiree health care benefits is a matter of even greater significance. The level of this concern can be understood as follows:

- Many education employees are not covered by Medicare. Hence, they would not benefit from the changes that may be initiated at the federal level.

  While the problem of lack of Medicare coverage will be resolved over time because the Consolidated Omnibus Budget Reconciliation Act (COBRA) has made Medicare coverage mandatory for education employees hired after March 31, 1986, it will continue to be a reason for concern for the next 10 to 15 years.

- Even if all educators were covered by Social Security and Medicare, there is another dimension to the unique situation of educators. Almost all education employees participate in defined benefit pension plans. These pension plans often include provisions that allow educators to retire before age 65, the age at which one can receive Medicare benefits. Hence, educators are more likely to need health care coverage between the age of retirement and age 65 than other employees, who often participate in defined contribution plans.

- Retiree health plans for education employees are not subject to the Employee Retirement Income Security Act (ERISA). Thus, any innovative improvements that may be initiated by the federal government under the ERISA program may not benefit education employees.



Thus, apart from dealing with the problems of retiree health care benefits that the United States is struggling with as a nation, education employees have to tackle certain additional problems.

The National Education Association's leaders are concerned about the issue of retiree health care benefits. This concern is evident from the fact that the NEA Standing Committee on Benefits, the NEA Legislative Committee, and the NEA Retired Advisory Council are actively addressing this issue.

Leaders of state Associations have also expressed a high level of concern. Recently NEA Research surveyed these leaders to rate the relative importance of various types of employee benefit issues. These leaders rated health insurance benefits, particularly retiree health care benefits, as the most important employee benefits issue.

The National Education Association supports the idea of a national health insurance plan through its resolutions and through its legislative agenda. In the face of a strong American Medical Association lobby against a national insurance plan, however, such a plan is unlikely to materialize in the near future. In the meantime, there is a consensus among the NEA leadership that in the absence of a national health insurance plan, Associations may be able to address the issue of retiree health care benefits more effectively at a state level. The NEA Standing Committee on Benefits, for example, encourages

Associations to seek statewide health plans for retired education employees.

Unfortunately, our knowledge about how state and local governments are dealing with the issue of health care benefits for retired education employees has been limited. We have not known, for example, the percentage of states and local school districts that are providing retiree health care benefits, the percentage of health plans that are offered through a retirement system, and the percentage of school districts where retirees and actives are in the same plan. We also have not known whether these benefits are adequate and affordable for education employees and who pays for these benefits. Using empirical data gathered from state and local Associations, the present study fills this gap in our knowledge.

Organization of the Report

This study uses data from two surveys. The Data and Methodology section of the report provides background information on how the two surveys were conducted. It also describes the nature of the data, the method of data analysis, and the method of data presentation.

The Findings section reports survey results as they relate to availability, adequacy, and affordability of retiree health care benefits.

The final section of the study recapitulates the major findings, describes the American health care dilemma, and discusses implications of the results for the Associations.

Data and Methodology

A retired education employee may participate in a statewide retiree health plan or a local school district plan. To cover both of these possibilities, the present study has used two sources of data:

- A mail survey of the 200 largest local education Associations
- A telephone survey of the 50 state education Associations

Survey of Local Health Plans

NEA Special Services, through its Member Benefits Corporation (MBC), conducted a mail survey of the 200 largest local education Associations. MBC contracted with Blue Cross and Blue Shield Associations in Chicago to design the survey instrument and elicit responses during the 1987-88 school year.

The survey gathered information primarily on health care plans for active employees. It nonetheless included a few questions on retiree health plans. For example, the survey asked:

- Is there a health plan in which retired education employees can participate?
- If yes, is it the same as the health plan for actives?
- What proportion of the premium is paid by the retiree?

NEA Research borrowed data from MBC and analyzed the retiree health care questions for purposes of the present study.

Survey of State Health Plans

A telephone survey of statewide retiree health plans was conducted by NEA Research during 1988. This survey asked state Association retirement and benefits contacts in all 50 states whether there is a statewide health plan for retired education employees in their state.

If such a plan does not exist, they were asked whether any steps are being taken to establish a statewide retiree health plan. If the plan does exist, they were asked the following questions about the characteristics of their plan:

- How is the plan administered? Is it administered through the retirement system?
- What benefits are provided?
- What portion of the premium is paid by the retiree?
- How is the plan funded?
- Are retirees better off, the same, or worse off than actives?

The data gathered through this telephone survey are included in this study.

Validity and Reliability of Data

In any survey, the validity of data is as good as the knowledge of the person reporting the data. The present study is no exception. To assure the validity of the data reported here, however, certain additional steps were taken. For example, aggregate findings of the present study were compared with those from

other sources of information such as the Martin E. Segal Company (Mackin 1988), Workplace Economics (1988), and the U. S. Department of Labor (1988). The results of the present study, in general, are not significantly different from those of other studies.

The term "reliability" refers to the accuracy of the measurement process itself. In order to assure reliability, a copy of the appendixes was mailed to all respondents. The respondents were requested to review the data for accuracy. A few corrections were made as a result of this process.

Method of Data Analysis

Most variables in the data from both surveys are categorical in nature. That is, they consist of a "yes" or "no" answer. The first stage of analysis of this type of data is to examine the frequency distributions of variables. Therefore, simple frequency tables were used to study the univariate distribution of the major variables.

The second stage of data analysis consisted of a bivariate and multivariate analysis. Again, given the categorical nature of data, a simple cross-tabulation technique was used. For example, to study the differences between health plans that are administered by a retirement system and those administered by another state agency, the plan administration variable was cross-tabulated against other variables of interest.

Method of Data Presentation

The data in this report are presented in the form of tables as well as in appendixes. Summary data are presented in the tables, and state-by-state data are listed in the appendixes.

Findings

The major findings of the school district health plan survey and state health plan survey follow. These surveys were conducted independently; therefore, the results are not always comparable. Whenever possible, a comparison between the results from the two surveys is made.

Table 1. Availability of Group Health Coverage to Retired Education Employees through Statewide Health Plans

Category of response	Number of states	Percentage of states
Availability—		
Coverage is available	29	58
Coverage is not available	21[a]	42
TOTAL	50	100
Plan is administered—		
by a retirement system	18	62
by another state agency	11	38
TOTAL	29	100

[a]Efforts for a state plan are being made in 8 of these 21 states (see Appendix A).

Availability of Retiree Health Plans

The results of the study show that 29 states offer a statewide health plan to retired education employees (Table 1). Of the 21 states that do not offer a plan, education Associations in 8 states were making efforts to obtain such a plan (Appendix A). Associations in the remaining 13 states were not actively involved in efforts to establish a retiree health plan.

Retiree health care coverage may be available through a school district plan in states that do not have a statewide plan. District coverage may also be available in states where a state plan exists but the school district may have chosen to stay out of the state plan. The results of the school district survey show that 80 percent of the school districts that responded to the survey offer retiree health benefits (Table 2). In 67 percent of these districts, both retirees and actives are in the same plan.

Table 2. Availability of Group Health Coverage to Retired Education Employees through School Districts

Category of response	Number of districts	Percentage of districts
Availability—		
Coverage is available	74	80
Coverage is not available	2	2
Don't know/No answer	16	17
TOTAL	92	100[a]
Plan Setup—		
Retirees are in the same plan as actives	62	67
Retirees are in a separate plan	16	17
Don't know/No answer	14	15
TOTAL	92	100[a]

[a]Percentages do not add up to 100 due to rounding.

Availability of Health Plans through a Retirement System

How many states offer a statewide retiree health plan through a retirement system? The survey shows that the majority of the states that offer health insurance to retired education employees offer it through a retirement system. Of the 29 states that offer statewide plans, 18 offer these plans through a retirement system (Table 1). The remaining 11 states offer the plans through another state agency, such as a state insurance agency.

Growth of Statewide Health Plans

The number of statewide retiree health plans has almost doubled in the past decade. Of the 29 states that currently offer statewide plans, 13 states began their programs in the last ten years (Table 3). The rate of growth of statewide health plans has been even faster in the past five years. Of the 13 state plans that were implemented in the last ten years, 6 began in the past five years.

The data in Table 3 show that the newer plans tend to be administered by a retirement system. For example, 27 percent of the plans administered by retirement systems were established in the past five years. Only 9 percent of the plans administered by another state agency are less than five years old. A state-by-state listing of retiree health plans by each plan's age is shown in Appendix B.

Availability of Health Plans in Social Security and Non-Social Security States

Educators in 13 states are not covered by Social Security. These states are Alaska, California, Colorado, Connecticut, Kentucky, Illinois, Louisiana, Maine, Massachusetts, Missouri, Nevada, Ohio, and Rhode Island. These states are more likely than Social Security states to have a statewide health plan (Appendix A); 70 percent of the non-Social Security states have a statewide retiree health plan, compared with 54 percent of the Social Security states.

Statewide health plans in non-Social Security states are more likely to be offered through a retirement system than through another state agency. In non-Social Security states, 67 percent of the statewide retiree health plans are offered through the retirement system. In Social Security states that figure is 60 percent.

Thus, non-Social Security states are more likely to have a statewide retiree health plan than Social Security states, and they are more likely to offer this plan through a retirement system. This is understandable because prior to March 1986 educators in non-Social Security states had no Medicare coverage. Yet four non-Social Security states (California, Maine, Missouri, and Nevada) do not have a statewide health plan. State Associations in two of these states, California and Missouri, are

Table 3. Percentage Distribution of Statewide Retiree Health Plans by Their Characteristics and by Their Age

Characteristics of health plans	Age of plan			
	Less than 5 years	5-10 years	More than 10 years	Unknown
	%	%	%	%
Plan is administered—				
by a retirement system	27	17	50	0
by another state agency	9	36	54	9
Plan is located in—				
a non-Social Security state	11	22	55	11
a Social Security state	25	25	50	0
All plans	21	25	52	3
(number of plans)	(6)	(7)	(15)	(1)

currently making efforts to obtain a statewide retiree health plan.

Availability of Health Plans to Various Groups of Education Employees

The present study gathered information on whether certain groups of education employees are eligible to participate in a statewide retiree health plan:

- Public school teachers
- Public school educational support personnel (ESP)
- Higher education faculty
- Higher education ESP

A state-by-state listing of groups of education employees covered by a statewide health plan is shown in Appendix C. The results show that, while the coverage is available to teachers in all states that have a statewide retiree health plan, coverage is not available to other groups of education employees. For example, coverage is not available to public school ESP in six of these states (Appendix C). Also, it is not available to higher education faculty and higher education ESP in eight of these states.

The results also show significant differences in the coverage of different groups of education employees by plan characteristics such as the plan's age, administrative setup, and Social Security coverage status. Health plans established in the past five years are less likely to cover higher education employees (Table 4). Approximately one-half of the new health plans, as compared to more than three-fourths of the old plans, or plans established more than five years ago, cover higher education employees.

Public school ESP, higher education faculty, and higher education ESP are also more likely to be covered by the plan if the plan is administered by a state agency other than a state retirement system and if the plan is located in a non-Social Security state (Table 4).

Adequacy of Retiree Health Care Benefit Options

In studying retiree health care benefit options, one of the fundamental issues is adequacy of benefits. Although difficult to define, adequacy of benefits may be regarded simply as coverage of services most needed by the retirees.

Retirees have specific health care needs. Given ailments typical for this age group, retirees need coverage for long-term and chronic illnesses. On the other hand, contrary to the rocking-chair notion of retirement, many of today's retirees move after retirement, travel, or live in different parts of the country as the seasons change. For these reasons, a health plan that offers only a local health maintenance organization (HMO) or a local preferred provider organization (PPO) option may impose unnecessary restrictions on the retiree.

Table 4. Percentage Distribution of Statewide Retiree Health Plans by Their Characteristics and by Their Coverage of Different Groups of Education Employees

Characteristics of health plans	Groups of education employees			
	Public school		Higher education	
	Teachers	ESP	Faculty	ESP
	%	%	%	%
Plan is administered—				
by a retirement system	100	72	61	66
by another state agency	100	91	91	82
Plan is located in—				
a non-Social Security state	100	67	55	55
a Social Security state	100	85	80	80
Plan was established—				
in the past 5 years	100	71	43	57
more than 5 years ago	100	82	82	77
All plans	100	86	70	70
(number of plans)	(29)	(23)	(21)	(21)

Are the benefit options offered under health plans for retired education employees designed to meet the special needs of these retirees? Survey data were examined for these and other aspects of adequacy of benefit options. The findings that follow will help to assess this question.

The survey shows that all of the statewide health plans offer either a Medigap option or a basic health care coverage option (Table 5). Medigap coverage includes benefits to fill the gaps in coverage left by Medicare. Basic benefits are offered in place of Medicare. They are offered to retirees who are not qualified for Medicare coverage. These include early retirees or retirees in non-Social Security states.

Alternative Delivery Systems

The survey also shows that, in addition to a basic or a Medigap option, statewide health plans frequently offer an alternative delivery system (ADS) option such as an HMO or a PPO. The term "ADS" refers to those health care delivery systems that serve as an alternative to Blue Cross/Blue Shield or to conventional indemnity health insurance plans.

A brief discussion of the ADS movement will help to describe the significance of the findings that follow. The ADS movement began in the form of Kaiser Permanente's HMOs and has evolved to include PPOs, which were conceived by researchers at the InterStudy Group. The main difference between an HMO plan and a traditional health insurance plan is that an HMO uses the concept of providing almost all services under one roof. An HMO may employ physicians or use a designated network of physicians to deliver services. This delivery system limits the choice of providers of health care services. HMOs have certain positive as well as certain negative aspects. On the positive side, HMOs encourage prevention and offer services such as annual physical examinations and well-baby care, which are not usually covered by a traditional health insurance plan. On the negative side, HMOs use a capitated payment system that provides services on the basis of per capita payment regardless of the type or quantity of services. This practice encourages HMOs to conserve on services and ultimately on the quality of care.

Traditional health insurance offers a delivery system in which providers of health care services are not centralized. Consumers are free to choose any provider. The payment is made by a third party on a fee-for-service basis. Little incentive exists to conserve on services or emphasize preventive care. The system encourages overuse of expensive services such as high technology. The quality of care under this type of system, however, is deemed to be high.

Table 5. Benefits Offered under School District and Statewide Health Plans

Benefit option	Percentage of districts (N=92)	Percentage of states (N=29)
Basic or Medigap plan[a]	87	100
An HMO option[a]	75	65
A PPO option[a]	28	41
Dental benefits	75	17
Vision benefits	13	17
Cost containment program	38	65
Wellness program	15	14
Long-term care program	—	28
Flexible/Cafeteria plan	13	—

[a] These options usually include prescription drug benefits.
— Information not available

The quality of care under PPO plans falls somewhere in between an HMO and a traditional health insurance plan. A PPO plan provides incentives to consumers to choose certain cost-efficient providers known as PPO physicians or PPO hospitals. A consumer is free to choose a non-PPO provider, but the coverage is reduced in such a way that the consumer may have to pay a higher deductible. In the case of HMOs, the consumer who chooses a non-HMO provider has no coverage at all. PPOs tend to preserve the fee-for-service system of payment. PPOs are assumed to work best in areas where there is an excess of providers and competition among providers can therefore control cost.

Because of the nature of their organization, HMOs and PPOs are usually available only on a local basis. Thus, they are inadequate for retirees because they limit a retiree's ability to move to another part of the country for a long period of time.

The survey results show that alternative delivery systems, HMOs and PPOs, are a common feature of statewide retiree health plans as well as of school district plans. A comparison of these plans in Table 5 shows that, while the HMO option is more common in school district plans, the PPO option is more common in state plans. For example, 65 percent of the statewide health plans, compared with 75 percent of the school district plans, offer HMOs. PPOs are offered by 41 percent of the state plans, compared with 28 percent of school district plans.

Two points should be noted here. First, HMOs and PPOs may be offered to retirees in many states, but participation in these plans by the retirees has been relatively low. The Health Care Financing Administration (HCFA) started offering HMO and PPO programs to Medicare beneficiaries after the passage of the Tax Equity and Fiscal Responsibility Act legislation. Most of these programs are offered on a demonstration basis, and their success has been limited. The HCFA (1988) estimates that about 10 percent of the Medicare beneficiaries enroll in HMOs and PPOs.

Second, in many situations a retiree has a choice to participate in an HMO, a PPO, or a traditional health insurance program. This is known as a multiple choice plan. Unfortunately, multiple choice plans encourage adverse selection; that is, individuals in need of the most health services tend to concentrate in the plan with the highest coverage. The end result of adverse selection is an increase in the overall cost of the plan.

Other Features

As indicated earlier, retirees have unique health care needs. They need more long-term care services than younger employees. Do statewide retiree health plans offer long-term care benefits? The results of the present study show that the benefit of long-term care is not widely offered by statewide retiree health plans. Only 28 percent of the plans offer this benefit (Table 5).

This study also looked at the cost containment and wellness features of the state and district health plans. The results show that cost containment

Table 6. Percentage Distribution of Statewide Retiree Health Plans by Their Characteristics and by Their Benefit Options

Characteristics of health plans	Benefit options						
	HMO option	PPO option	Long-term care	Dental care	Vision care	Cost containment program	Wellness program
	%	%	%	%	%	%	%
Plan is administered—							
by a retirement system	55	33	17	22	17	67	6
by another state agency	81	54	45	9	9	64	27
Plan is located in—							
a non-Social Security state	56	0	44	22	22	44	22
a Social Security state	70	60	20	15	10	75	10
Plan was established—							
in the past 5 years	57	57	14	14	0	71	0
more than 5 years ago	68	36	32	18	18	64	18
All plans	65	41	28	17	14	66	14
(number of plans)	(19)	(12)	(8)	(5)	(4)	(19)	(4)

programs are more common among state plans than district plans. Almost two-thirds of the state plans have a cost containment program, compared with approximately one-third of the district plans. The prevalence of a wellness program in both state and district plans is relatively low. Less than one out of six of these plans has a wellness program (Table 5).

The study further explored stand-alone benefits, such as vision and dental benefits. While the availability of vision care benefits is very low under both state and district plans, only 13 to 17 percent of these plans offer vision benefits, dental benefits are more common under district plans. For example, 75 percent of the district plans offer dental benefits, compared with 17 percent of the state plans.

Prescription drugs, another common stand-alone benefit, are available in all cases. They are provided either as a part of the basic major medical plan or as a stand-alone benefit through a prescription drug card. The list of states by benefit options is shown in Appendix D.

The above findings suggest that the coverage for retiree health care under both state and district plans is inadequate in several respects. Many of these plans offer HMOs and PPOs that limit retirees' freedom of choice and their ability to move to different parts of the country. In many instances both state and district plans offer HMOs, PPOs, and traditional insurance, the multiple choice option that encourages adverse selection. These plans are also inadequate because very few of them offer long-term care and wellness programs.

Table 6 shows be options by different characteristics of statewi health plans. The following differences emerge:

- Dental and vision benefits are more common among plans administered by retirement systems. HMO and PPO options, wellness, and long-term care benefits are more common among plans administered by other state agencies.
- Long-term, dental, and vision care benefits, as well as wellness programs, are more common among plans located in non-Social Security states. HMO and PPO options and cost containment programs are more common among Social Security states.
- Compared with old plans, new plans tend to include a PPO option and a cost containment program, but they are less likely to include stand-alone benefits such as dental, vision, and long-term care.

These findings show that the older, more experienced plans are liberal in their benefits design because they tend to include various stand-alone benefits. They may also be learning that cost containment programs are not succeeding. Therefore, they are more likely to include a wellness program in their benefits package, compared with the newer, less experienced, plans.

The older plans seem to have realized the need for long-term care benefits because they are more likely to include a long-term care program, compared with the newer plans. The newer plans, on the other hand, may be taking a wait-and-see attitude in light of recent Congressional interest in the area of long-term care.

Affordability of Retiree Health Care Benefits

Health care benefits are becoming unaffordable. The latest data show that the average annual health plan cost per employee has increased from $1,985 in 1987 to $2,354 in 1988 (Kelly Communications 1989). The cost for a retiree not covered by Medicare is more than double that of an active employee (Mackin 1987).

Health care costs are expected to continue rising faster than the cost-of-living adjustment (COLA) retirees may receive. In the past decade or so, health care costs have been consistently 5-10 percent higher than the COLAs. It is also expected that retiree health care costs will more than double by the year 2000. This will make retiree health care benefits increasingly unaffordable (Paul and Disney 1988).

The present study did not collect data on amount of premium paid by retirees because of the complexities involved. However, the study did look at the affordability of benefits in relation to who pays for the retiree health care benefits and what percentage.

A comparison of the percentage of the premium paid by a retiree under a statewide health plan and under a district health plan shows that retirees are better off under statewide health plans. Retirees pay no premium in 48 percent of the statewide plans. In only 24 percent of the school district plans do retirees pay no premium (Table 7).

A similar conclusion is apparent when the percentage of plans in which retirees have to pay 100 percent of the cost of their health insurance is examined. Retirees pay the full cost of the plan in 21 percent of the statewide plans. They pay full cost in 43 percent of the district plans (Table 7).

The percentage of plans in which a retiree and the employer share the cost of the health plan is not significantly different between statewide and district health plans. Retirees share the cost of their coverage in approximately one-third of both types of plans.

A state-by-state listing of the level of premium paid by the retirees under a statewide health plan is shown in Appendix E.

A further analysis of the statewide health plans by the level of premium paid by the retiree shows that retirees are better off under plans that are administered through a retirement system (Table 8). Two out of three of the state health plans that are administered by a retirement system do not require any premium contribution from the retiree. The figure for the plans administered by another state agency is one out of six.

The results of this analysis also show that there are no significant differences in the availability of a fully paid retiree health care benefits plan either by the state's Social Security coverage status or by the health plan's age (Table 8).

Table 7. Percentage of Monthly Premium Paid by a Retired Education Employee

Percentage of premium paid by the retiree	Percentage of districts (N=53)	Percentage of states (N=29)
None	24	48
1% – 49%	26	7
50% – 99%	6	21
Full	43	21
Unknown	—	3

— Information not available

Table 8. Percentage Distribution of Statewide Retiree Health Plans by Their Characteristics and by the Level of Premium Paid by a Retiree

Characteristics of health plans	Level of premium paid by a retiree				
	None	1% - 49%	50% - 99%	Full	Unknown
	%	%	%	%	%
Plan is administered—					
by a retirement system	66	5	17	6	6
by another state agency	18	9	27	45	0
Plan is located in—					
a non-Social Security state	44	0	44	11	0
a Social Security state	50	10	10	25	5
Plan was established—					
in the past 5 years	57	0	0	29	14
more than 5 years ago	45	9	27	18	0
All plans	48	7	21	21	3
(number of plans)	(14)	(2)	(6)	(6)	(1)

Coverage for Spouse

An important aspect of an affordable retiree health care benefits plan is the availability of employer-paid coverage for the retiree's spouse. This is one area in which benefits for education employees lag behind those for other industry employees. An earlier study conducted by NEA shows that, compared with other industries such as banking, insurance, and manufacturing, the incidence of availability of fully paid or subsidized health care coverage for the spouse is much lower among education employees (NEA 1988).

The results of this study show that, while spousal coverage is universally available, the coverage is not subsidized in the majority of the statewide health plans (Appendix F). Approximately two-thirds of the plans do not offer subsidized health insurance coverage for a retiree's spouse (Table 9). The results also show that spouses are relatively better off under—

- plans administered by a state agency other than a retirement system,
- plans in non-Social Security states,
- plans established more than five years ago.

Plans with these characteristics are more likely to offer a subsidized coverage for the spouse.

Funding Arrangements

The survey of state plans gathered information on how the plans are funded. For the purposes of the present study, these funding arrangements are divided into the following four categories:

- Funded through retiree contributions
- Funded through retiree and state contributions
- Funded through state and/or local appropriations
- Funded through direct appropriations to retirement systems and/or actuarially funded

Appendix G provides a listing of statewide health plans by the type of funding arrangement. The results are summarized in Table 10.

Approximately one-third of the state plans are funded through direct appropriations to retirement systems (Table 10). Some retirement systems, such as Michigan, Ohio, and Texas, determine the level of required funding using actuarial methods. In more than half of the state plans, however, the plans are funded through established premiums paid by both retirees and the state.

Plans administered through a retirement system, plans in non-Social Security states, and the plans established in the past five years are most likely to use the direct appropriations funding arrangement (Table 10).

Table 9. Percentage Distribution of Statewide Retiree Health Plans by Their Characteristics and by Their Subsidization of Spouse's Premium

Characteristics of health plans	Premium for spouse is subsidized	Premium for spouse is not subsidized	Unknown
	%	%	%
Plan is administered—			
by a retirement system	33	56	11
by another state agency	36	64	0
Plan is located in—			
a non-Social Security state	44	33	22
a Social Security state	30	70	0
Plan was established—			
in the past 5 years	0	86	14
more than 5 years ago	45	50	4
All plans	34	59	7
(number of plans)	(10)	(17)	(2)

Table 10. Percentage Distribution of Statewide Retiree Health Plans by Their Characteristics and by Their Funding Arrangements

Characteristics of health plans	Funding arrangements				
	Retiree premiums	Retiree and state	State/local approp.	Approp. to ret. system	Unknown
	%	%	%	%	%
Plan is administered—					
by a retirement system	6	28	11	50	6
by another state agency	45	36	18	0	0
Plan is located in—					
a non-Social Security state	11	44	0	44	0
a Social Security state	25	25	20	25	0
Plan was established—					
in the past 5 years	29	14	0	57	0
more than 5 years ago	18	36	18	23	4
All plans	21	31	14	31	3
(number of plans)	(6)	(9)	(4)	(9)	(1)

Are Retirees Better Off Than Actives?

When asked about a comparison of health care benefits for retired and active education employees, more than one-half of both the state and the local survey respondents indicated that the benefits are the same (Table 11).

Table 11. Perceived Comparison of Health Insurance Coverage of Retired and Active Education Employees under State and District Plans

Comparison	Percentage of districts (N=92)	Percentage of states (N=29)
Coverage for retirees is the same as active	65	55
Coverage for retirees is not the same	11	45
Coverage for retirees is better than actives	—	17
Coverage for retirees is worse than actives	—	28
No answer	23	0

— Information not available

In state plans under which coverage for retirees and actives is different, the respondents were asked whether retirees are better off or worse off than actives. This information was not available for the district plans. In the majority of these state plans, retirees are perceived to be worse off than actives (Table 11). Actives are more likely to have certain free-standing benefits, such as dental and vision benefits, which are not usually available to retirees under Medicare or state health plans, a circumstance that may account for the perception that retirees are worse off.

A state-by-state listing of the perceived comparison of health care benefits of retired and active education employees is shown in Appendix H.

Possible Future Changes

According to survey respondents, the majority of state plans expect to make changes in their benefit designs in the coming years (Appendix I). These changes include addition of dental and vision benefits and modifications in plan design.

Several plans expect to see higher premiums in the future. Data on the amount of premium increase expected by the state plans were not readily available through the survey respondents. Other sources of data, such as the Martin Segal Company's 1988 survey (Mackin 1988), suggest that, on the average, premiums of retiree health plans will increase by 11.3 percent. This is almost twice the amount of increase in the medical care component of the Consumer Price Index.

Survey respondents also expect changes in the level of premium contribution made by the retirees. Although efforts are being made to decrease the level of retiree contributions to some plans, current cost trends suggest retirees may have to contribute more, not less, toward their premium.

Only a few plans expect to increase cost containment efforts. However, more plans hope to introduce a wellness program. Lack of success of cost containment efforts makes renewed emphasis on wellness almost imperative.

Implications of Results

This study has looked at empirical data on how state and local governments are dealing with the issue of health care benefits for retired education employees. The issue revolves around availability, adequacy, and affordability of these benefits. Rising costs of health care and unfunded liability for retiree health care benefits loom as major reasons for concern over the issue. This section highlights survey results in the context of the U.S. health care environment, describes the dilemma that policymakers face, and discusses implications of the results for the Associations.

Survey Highlights

Availability of Retiree Health Care Benefits

Health care benefits for retired public education employees are not universally available through their place of employment. Those who cannot obtain benefits through a state or school district plan may, of course, purchase health insurance independently through any major insurance carrier, although this type of insurance is expensive.

Adequacy of Retiree Health Care Benefits

The issue of adequacy of benefits is particularly relevant for retirees. They have special health care coverage needs, for example, coverage for long-term care and chronic illnesses. However, only about one-fourth of the state plans offer this type of benefit.

Three-fourths of the state and district plans offer an HMO option. The PPO option is more commonly offered by state plans. Approximately 41 percent of state plans, compared with 28 percent of district plans, offer a PPO option. A retiree health plan including HMOs and PPOs is less appealing and inadequate for retirees because it limits the choice of providers, limits retirees' ability to move to other states, and encourages adverse selection.

Affordability of Retiree Health Care Benefits

The main issues in the provision of retiree health care benefits are their affordability and how they are paid for. With the rising cost of health care, it is increasingly difficult for retirees to pay for these benefits. The results of this study suggest that retirees are better off under statewide health plans. A greater percentage of statewide health plans, compared with school district plans, pay the full cost of a retiree's health insurance premium. This percentage is even greater for those states where the plan is administered by a retirement system.

The availability of subsidized coverage for a spouse is closely related to the issue of affordability of retiree health care benefits. Coverage for a retiree's spouse is available through almost all state plans, but only one-third of the state plans subsidize this coverage.

This survey reveals that many health plans are expecting higher premiums next year. This is understandable because health care costs in the United States are spiraling out of control. In the past few years, for example, health care costs have been consistently 5 to 10 percent higher than the CPI. Computations by Enthoven (1988) suggest that retiree health care costs may consume 13 percent of the GNP in the year 2020. Reimert (1988) argues that if health care costs continue to rise at the current rate, they may

consume all of the GNP of the United States at some point in the future. In practice, however, this will not happen. Corrective forces are bound to come into play.

One may ask, why are health care costs out of control? Of the many factors that influence health care costs, the following are noteworthy:

- Nature of the Health Care Delivery System. The nature and characteristics of health care contribute to the rising cost of health care indirectly. Health care in the United States is predominantly a multipayer fee-for-service system. The provider reimbursement mechanism in this system incorporates little or no incentive for the consumer or the provider to contain costs. Payment is made by a third party, generally a health insurance company. Under this system, providers of health care services get more money if they conduct more tests, use advanced technology, and offer more services. The system is designed to provide acute care and emergency care services. No emphasis is placed on long-term care and preventive services. The U.S. legal environment encourages providers to practice defensive medicine.
- Inflation and Service Intensity. These factors have a direct impact on the rising cost of health care. They include general inflation, medical inflation, and service intensity. The term "service intensity" refers to the quantity and type of services used and includes the cost of services rendered by hospitals and physicians, cost of supplies, and cost of advances in medical technology.
- Changing Demographics. Because of the declining birthrate and improved living conditions, Americans are not only collectively aging but also are living longer. Health problems generally increase with age, and so does the cost of health care.

Expectation of State Plans to Contain Health Care Costs

Concerning ways to deal with rising health care costs, more state plans expect to focus on a wellness program than on a cost containment program. The focus on wellness is understandable because cost containment programs impose undue hardships and penalties on employees instead of focusing on providers and holding the providers accountable for their actions and methods.

As a nation, the United States has failed to control health care costs. Cost containment approaches assume that consumers are responsible for rising health care costs; that is, they overuse and misuse health care services, which gives rise to higher health care costs. For example, cost containment programs, such as preadmission review, second surgical opinion, and out-patient surgery, all impose penalties on the consumer. It is the provider, however, not the consumer, who determines how many tests will be performed, what type of test will be performed, and which services will be rendered. It is the provider, not the consumer, who submits inaccurate claims to get reimbursed for services that were never performed. And it is the provider, not the consumer, whose profit margins are directly proportional to the number and type of services performed. Yet few, if any, cost containment programs hold the providers responsible for their actions.

Expectation of State Plans to Deal with Unfunded Liability

Because the subject is so new and complex, the survey did not collect data on unfunded liability. The study did look, however, at how health plans are being funded. The results show that only a handful of state plans, for example, Michigan, Ohio, and Texas, are using a prefunding or actuarial funding method to accrue funds for retiree health care benefits. It should be noted that publication of the proposed FASB rules that employers accrue unfunded liability for retiree health care benefits has brought the issue of unfunded liability to national attention (Mosso 1988). The estimates of unfunded liability for retiree health care benefits vary from $250 billion to $2 trillion (Doran et al. 1987; Chollet 1988). Despite the reforms in the Social Security tax, the Medicare Hospital Insurance Fund is expected to have a $10.8 billion deficit in the year 2000 (EBRI 1988). The major reason for this huge unfunded liability is that retiree health care benefits are funded on a pay-as-you-go basis; and, unlike pensions, no funds to pay for these benefits have been accumulated. Discussions with actuaries suggest that the unfunded liability for retiree health care benefits for education employees may be approximately $20 billion.

American Health Care Dilemma

The dilemma for policymakers is whether the fee-for-service system should be preserved or whether the health care system should be regulated in the form of a national health insurance program. Despite its tendency to inflame health care costs, the fee-for-service system has certain merits. The consumer in this system has the freedom to choose any provider without worrying about payment for the provider's services because these services will be paid by someone else. This system is unique in the world. It encourages competition among providers, enhances quality of care, and leads to innovations in medical technology. Despite its promise of universal access to health care, a regulated system in the form of national health insurance has its drawbacks. A regulated system offers little incentive for high-quality care or advances in medical technology.

Americans love their freedom to choose. They cherish technological innovations. Their society is based on diversity and pluralism, a free market economy, and open competition that promotes technological advances. They do not want government to regulate their lives. As a result, they have developed a health care system that offers them the freedom to choose their own physician. They want a system that offers diversity and the highest quality of care using the latest and the best medical technology. However, they are dismayed that the system is not working as conceived by researchers at Baylor College in Texas.

National and state legislators have addressed the health care dilemma half-heartedly. They have tried to preserve the fee-for-service system and at the same time introduce legislation to regulate the system. Medicare's DRG (Diagnosis Related Group) program is a living example of this middle-of-the-road approach. This approach has increased overall health care costs. The DRG program, for example, exacerbated overall health care costs by shifting inpatient costs to outpatient settings and by shifting Medicare's costs to other private and public sector payers.

The U.S. Congress is now looking into the reform of the physician payment system (Ginsburg 1989). A relative-value scale is being developed for this purpose. Those monitoring the development of this scale are already expressing skepticism (Etheredge and Dobson 1988).

To resolve this dilemma, leading health policy analysts have recently proposed certain reforms in the U.S. health care system. These reforms vary from reforming the system incrementally to cover the uninsured (Enthoven and Kronick 1988) to dismantling the entire health care system and restructuring it into a national health insurance plan (Himmelstein et al. 1989).

If the total restructuring approach is followed, legislators would need to make changes in other systems in the society that affect the health care system. For example, a national health insurance plan such as the one in existence in Great Britain or Canada is not likely to survive in the United States because of the legal environment, unless necessary changes in laws are passed to assure the success of such a system.

Implications for the Associations

A strategic objective of NEA is to improve the compensation of the educational work force, which includes health care benefits. The rising cost of health care benefits and the issue of unfunded liabilities for such care pose a potential squeeze on the resources available for salaries. It will become increasingly difficult to maintain the current level of benefits of education employees and at the same time achieve appropriate salary gains. A relatively high level of attention and resources of state and local Associations is now being consumed by health care issues. Understanding and concerted effort on health care issues may continue to demand the Association's attention as an important part of its educational agenda.

The results of this report have important implications for state Associations. These implications are described as follows:

- Associations need to educate and organize members about health care issues.
- While the implementation of a national plan may not be near, it may be possible for the Associations to look at how the health care system in their own state is organized. Associations need to look into the possibility of establishing a statewide health plan that offers adequate and affordable health care benefits to retired education employees. Associations also need to look into the possibility of reforming the finance and delivery of retiree health plans.
- In the area of plan design, especially in the case of multiple choice plans, plans that offer HMOs, PPOs, and traditional indemnity

insurance, Associations need to assess the adverse selection factor. Multiple choice plans are known to encourage adverse selection and, hence, increase health care costs (NEA 1988).

- In negotiating a cost containment program, Associations need to negotiate a program that is directed at providers rather than consumers. At the same time, such benefits as wellness, preventive care, and long-term care need to be emphasized. In addition, a continuous review of aggregate utilization data, a continuous review of the provider payment system, and an incentive system for consumers to monitor their insurance company's explanation of benefit statements may help employers and employees to contain health care costs.
- To address the issue of unfunded liability for retiree health care benefits, Associations need to assess the magnitude of the unfunded liability and the ways to deal with the situation should GASB follow FASB's proposed rule.

No doubt, health care in the United States is chaotic. The United States spends more than one-half of a trillion dollars on health care and has the best and the most advanced medical technology in the world, yet consumer satisfaction with the system is lower than it is in countries like Canada and the United Kingdom where health care expenditures are half as much as those in the United States (Blendon 1988). Given the strength and the leadership position of the NEA and its affiliates, a resolution to the issue of retiree health care benefits may be achieved. Membership education, lobbying for statewide health plans that offer adequate and affordable health care benefits, and assessment of plan design and plan financing seem to be the main avenues to deal with the issue.

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Appendixes

Appendix A. List of States by Availability of a Statewide Health Plan for Retired Education Employees

State	Plan is not available	Plan is available through: Retirement system	Plan is available through: Another agency
Alabama		X	
Alaska		X	
Arizona	X		
Arkansas			X
California	X[a]		
Connecticut		X	
Colorado		X	
Delaware		X	
Florida	X[a]		
Georgia			X
Hawaii			X
Idaho	X		
Illinois		X	
Indiana			X
Iowa	X		
Kansas	X[a]		
Kentucky		X	
Louisiana			X
Maine	X		
Maryland	X		
Massachusetts			X
Michigan		X	
Minnesota	X[a]		
Mississippi	X[a]		
Missouri	X[a]		
Montana	X		
Nebraska	X[a]		
Nevada	X		
New Hampshire	X		
New Jersey		X	
New Mexico			X
New York		X	
North Carolina			X
North Dakota	X		
Ohio		X	
Oklahoma		X	
Oregon		X	
Pennsylvania			X
Rhode Island			X
South Carolina		X	
South Dakota	X		
Tennessee		X	
Texas		X	
Utah	X		
Vermont		X	
Virginia	X[a]		
Washington	X		
West Virginia			X
Wisconsin		X	
Wyoming	X		

[a]Associations in these states are making efforts to attain a statewide health plan.

Appendix B. Age of Statewide Health Plans for Retired Education Employees

State	Age of plan		
	Less than 5 years	Between 5 and 10 years	More than 10 years
Alabama		X	
Alaska			X
Arkansas		X	
Connecticut			X
Colorado		X	
Delaware		X	
Georgia			X
Hawaii			X
Illinois		X	
Indiana		X	
Kentucky			X
Louisiana		X	
Massachusetts	—	—	—
Michigan			X
New Jersey			X
New Mexico	X		
New York			X
North Carolina			X
Ohio			X
Oklahoma	X		
Oregon	X		
Pennsylvania			X
Rhode Island			X
South Carolina			X
Tennessee	X		
Texas	X		
Vermont			X
West Virginia			X
Wisconsin	X		

— Information not available

Appendix C. Groups of Education Employees Eligible to Participate in a Statewide Retiree Health Plan

State	Groups of education employees			
	Public school		Higher education	
	Teachers	ESP	Faculty	ESP
Alabama	X	X	X	X
Alaska	X			
Arkansas	X	X	X	X
Connecticut	X			
Colorado	X	X		X
Delaware	X	X	X	X
Georgia	X	X	X	X
Hawaii	X	X	X	X
Illinois	X			
Indiana	X			
Kentucky	X	X	X	X
Louisiana	X	X	X	
Massachusetts	X	X	X	X
Michigan	X	X	X	X
New Jersey	X	X	X	X
New Mexico	X	X	X	X
New York	X	X	X	X
North Carolina	X	X	X	X
Ohio	X	X	X	X
Oklahoma	X	X		
Oregon	X	X	X	X
Pennsylvania	X	X	X	X
Rhode Island	X	X	X	X
South Carolina	X	X	X	X
Tennessee	X		X	X
Texas	X	X		
Vermont	X			
West Virginia	X	X	X	X
Wisconsin	X	X	X	X

ESP = Educational Support Personnel

Appendix D. Benefit Options under Statewide Health Plans for Retired Education Employees

State	Benefit options							
	Medigap or basic	HMO[a] option	PPO[a] option	Long-term care	Dental care	Vision care	Cost containment program	Wellness program
Alabama	X	X	X		X	X	Yes	No
Alaska	X			X	X	X	No	No
Arkansas	X	X	X				—	—
Connecticut	X						No	No
Colorado	X	X					No	No
Delaware	X	X	X				Yes	No
Georgia	X	X	X				No	No
Hawaii	X	X	X				Yes	Yes
Illinois	X						—	No
Indiana	X						No	No
Kentucky	X	X					Yes	No
Louisiana	X	X		X			Yes	Yes
Massachusetts	X	X	X	X	X	X	Yes	Yes
Michigan		X	X				Yes	No
New Jersey	X	X	X				Yes	No
New Mexico	X	X	X	X			Yes	No
New York	X	X	X	X		X	Yes	No
North Carolina	X	X					Yes	No
Ohio	X			X			Yes	No (newsletter)
Oklahoma	X	X	X		X		Yes	No
Oregon	X	X	X				Yes	No
Pennsylvania	X						Yes	No
Rhode Island	X	X					No	No
South Carolina	X	X		X	X		Yes	Yes
Tennessee	X						Yes	No
Texas	X						Yes	No
Vermont	X						No	No
West Virginia	X	X		X			Yes	No
Wisconsin	X						No	No

[a]This type of plan usually includes prescription drug benefits.

— Information not available

Appendix E. Percentage of Premium of Statewide Health Plans Paid by Retired Education Employees

State	Percentage of premium paid by a retiree with Medicare	Percentage of premium paid by a retiree without Medicare
Alabama	2	56
Alaska	0	0
Arkansas	100	—
Connecticut	75	100
Colorado	0	0
Delaware	0	0
Georgia	25	25
Hawaii	0	0
Illinois	50	50
Indiana	100	100
Kentucky	0	0
Louisiana	50	50
Massachusetts	90	90
Michigan	0	23
New Jersey	0	0
New Mexico	100	100
New York	50	50
North Carolina	0	0
Ohio	0	0
Oklahoma	0	32
Oregon	0	—
Pennsylvania	100	—
Rhode Island	100	100
South Carolina	0	0
Tennessee	—	100
Texas	0	0
Vermont	0	0
West Virginia	54	33
Wisconsin	100	100

Note: Some of these plans may have certain minimum service requirements before a certain level of premium is paid by the state.

Appendix F. Provision for Coverage of Spouse of a Retired Education Employee under a Statewide Health Plan

State	Is spouse eligible?	Is premium for spouse subsidized? (% subsidized)	
Alabama	Yes	No	
Alaska	Yes	Yes	(100%)
Arkansas	Yes	No	
Connecticut	Yes	Yes	(25%)
Colorado	—	—	
Delaware	Yes	Yes	(100%)
Georgia	Yes	Yes	(39%)
Hawaii	Yes	Yes	—
Illinois	Yes	No	
Indiana	Yes	No	
Kentucky	Yes	Yes	—
Louisiana	Yes	No	
Massachusetts	Yes	Yes	—
Michigan	Yes	Yes	(90%)
New Jersey	Yes	No	
New Mexico	Yes	No	
New York	Yes	Yes	(35%)
North Carolina	Yes	No	
Ohio	Yes	Yes	(60%)
Oklahoma	Yes	No	
Oregon	Yes	No	
Pennsylvania	Yes	No	
Rhode Island	Yes	No	
South Carolina	Yes	No	
Tennessee	Yes	No	
Texas	Yes	No	
Vermont	Yes	No	
West Virginia	Yes	Yes	—
Wisconsin	Yes	No	

— Information not available

Appendix G. Funding Arrangements of Statewide Health Plans for Retired Education Employees

State	Funding arrangements			
	Retirees	Retirees and state	State and/or local approp.	Approp. to retirement system and/or actuarial
Alabama		X		
Alaska				X
Arkansas	X			
Connecticut		X		
Colorado				X
Delaware			X	
Georgia		X		
Hawaii			X	
Illinois		X		
Indiana	X			
Kentucky				X
Louisiana		X		
Massachusetts		X		
Michigan				X
New Jersey			X	
New Mexico	X			
New York		X		
North Carolina			X	
Ohio				X
Oklahoma				X
Oregon				X
Pennsylvania	X			
Rhode Island	X			
South Carolina	—	—	—	—
Tennessee		X		
Texas				X
Vermont				X
West Virginia		X		
Wisconsin	X			

— Information not available

Appendix H. Comparison of Health Insurance Coverage of Retired Education Employees under Statewide Plans with That of Active Education Employees

State	Coverage for retirees is		
	Better	Same	Worse
Alabama		X	
Alaska			X
Arkansas			X
Connecticut			X
Colorado	X		
Delaware		X	
Georgia		X	
Hawaii		X	
Illinois			X
Indiana		X	
Kentucky	X		
Louisiana		X	
Massachusetts		X	
Michigan		X	
New Jersey		X	
New Mexico		X	
New York		X	
North Carolina		X	
Ohio		X	
Oklahoma	X		
Oregon			X
Pennsylvania	X		
Rhode Island	X		
South Carolina		X	
Tennessee		X	
Texas		X	
Vermont			X
West Virginia		X	
Wisconsin			X

Appendix I. Possible Future Changes in Statewide Health Plans for Retired Education Employees

State	Possible changes
Alabama	Wellness and more cost containment programs may be introduced in the plan.
Alaska	State may remove health benefits from retirement system.
Arkansas	State may extend its contributions to retiree health plan.
Connecticut	State may increase its contribution to retiree health plan.
Colorado	Increase in premium is expected. Dental and vision benefits may be included in the plan.
Delaware	None.
Georgia	Dental and vision benefits may be included in the plan.
Hawaii	Dental and vision benefits may be included in the plan.
Illinois	None.
Indiana	Separate premium structure for retirees under the age of 65 may be introduced.
Kentucky	Retirees may be required to pay a part of the premium.
Louisiana	HMO may be excluded from the plan.
Massachusetts	None.
Michigan	Dental, vision, and hearing aid benefits may be included in the plan.
New Jersey	Maximum benefit limit may be increased to $1 million.
New Mexico	Government may make a contribution toward a retiree's health insurance premium.
New York	Increase in premium is expected.
North Carolina	Dental benefits and more cost containment may be included in the program.
Ohio	None.
Oklahoma	None.
Oregon	None.
Rhode Island	None.
South Carolina	Unknown.
Tennessee	Increase in premium is expected. Also, a PPO program and a greater level of utilization management may be introduced.
Texas	Changes in the plan may be made in response to changes in Medicare because of the Catastrophic legislation.
Vermont	System may pay 100 percent of premium.
West Virginia	A wellness program may be introduced. Also, the premium is expected to increase.
Wisconsin	An HMO option may be included in the plan. Also, changes in the plan may be made in response to Catastrophic legislation.

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